(NN) traction apparatus and equipment;

(OO) underpads and adult diapers, disposable and non-disposable;

(PP) walkers;

(QQ) water pitchers, glasses and straws;

(RR) weighing scales;

(SS) wheelchairs;

(TT) irrigation solution, i.e., water and normal saline;

(UU) lotions, creams and powders, including baby lotion, oil and powders;

(VV) first-aid type ointments;

(WW) skin antiseptics such as alcohol;

(XX) antacids;

(YY) mouthwash;

(ZZ) over-the-counter analgesics;

(AAA) two types of laxatives;

(BBB) two types of stool softeners;

(CCC) nutritional supplements; and

(DDD) blood glucose monitors and supplies.

(2) Urinary supplies. Urinary catheters and accessories shall be covered services in the medicaid/medikan program when billed through the durable medical equipment or medical supply provider. This expense shall not be reimbursed in the per diem rate of the cost report.

(3) Nutritional therapy. Total nutritional replacement therapy shall be prior authorized to qualify for reimbursement by the

durable medical equipment program. If not prior authorized, it is an allowable cost to be covered in the per diem rate.

(c) Payment for ancillary services, as defined in K.A.R. 30-10-200, shall be billed separately when the services or supplies are required.

(d) Payment for a day service program for clients of an ICF-MR shall be included in the per diem reimbursement. Providers shall allow the client or the client's guardian to select a day service program offered by another agency. The other agency must be licensed and unencumbered by documented service deficiencies which would prevent the provider from becoming certified or remaining certified as a medicaid provider. The provider must pay the actual cost of the service provided by the other agency up to 24 percent of the provider's approved per diem rate. Expenses incurred by the provider for this service are allowable expenses and may be reported on the provider's financial and statistical report.

(e) Payment shall be limited to providers who accept, as payment in full, the amount paid in accordance with the fee structure established by the medicaid/medikan program. The effective date of this regulation shall be April 1, 1992. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992.)

30-10-211. ICF-MR financial data. (a) General. The per diem rate or rates for providers participating in the medicaid/medikan program shall be based on an audit or desk review of the costs reported to provide client care in each facility. The basis for conducting these audits or reviews shall be the ICF-MR financial and statistical report MH&RS-2004. Each provider shall maintain sufficient financial records and statistical data for proper determination of reasonable and adequate rates. Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the ICF-MR and related fields shall be followed, except to the extent that they may conflict with or be superseded by state or federal medicaid requirements. Changes in these practices and systems shall not be required in order to determine reasonable and adequate rates.

(b) Pursuant to K.A.R. 30-10-213, ICF-MR financial and statistical reports, MH&RS-2004, (cost reports) shall be required from providers on an annual basis.

(c) Adequate cost data and cost findings. Each provider shall provide adequate cost data on the cost report. This cost data shall be in accordance with state and federal medicaid requirements and general accounting principles, shall be based on the accrual basis of accounting, and may include a current use value of the provider's fixed assets used in client care. Estimates of costs shall not be allowable except on projected cost reports submitted pursuant to K.A.R. 30-10-213.

(d) Recordkeeping requirements.

(1) Each provider shall furnish any information to the agency that may be necessary:

(A) To assure proper payment by the program pursuant to paragraph (2);

(B) to substantiate claims for program payments; and

(C) to complete determinations of program overpayments.

(2) Each provider shall permit the agency to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records shall include:

(A) Matters of the ICF-MR ownership, organization, and operation, including documentation as to whether transactions occurred between related parties;

(B) fiscal, medical, and other recordkeeping systems;

(C) federal and state income tax returns and all supporting documents;

(D) documentation of asset acquisition, lease, sale or other action;

(E) franchise or management arrangements;

(F) matters pertaining to costs of operation;

(G) amounts of income received, by source and purpose;

(H) a statement of changes in financial position; and

(I) actual cost of day care programs provided to ICF/MR clients.

Other records and documents shall be made available as necessary. Records and documents shall be made available in Kansas. Any provider who fails to provide any documents requested by the agency may be suspended from the ICF/MR program.

(3) Each provider, when requested, shall furnish the agency with copies of client service charge schedules and changes thereto as they are put into effect. The agency shall evaluate the charge schedules to determine the extent to which they may be used for determining program payment.

(4) Suspension of program payments to a provider. If the agency determines that any provider does not maintain or no longer maintains adequate records for the determination of reasonable and adequate per diem rates under the program, payments to that provider may be suspended until deficiencies are corrected. Thirty days before suspending payment to the provider, the agency shall send written notice to the provider of its intent to suspend payments. The notice shall explain the basis for the agency's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies.

(5) All records of each provider that are used in support of costs, charges and payments for services and supplies shall be subject to inspection and audit by the agency, the United States department of health and human services, and the United States general accounting office. All financial and statistical records to support costs reports shall be retained for five years from the date of filing the cost report with the agency. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991.)

Methods and Standards for Establishing Payment Rates-
Skilled Nursing and Intermediate Care Facility Rates

(ICFs/MR)

Usual and Customary Charges

The State shall retain all cost reports for a minimum of three years after receipt.

30-10-212. ICF-MR extra care. (a) Additional reimbursement for direct services shall be available to ICF's-MR for medicaid/medikan clients in need of extra care. Failure to obtain prior authorization shall negate reimbursement for this service.

(b) Extra care shall be considered a covered service within the scope of the program unless the request for prior authorization is denied. Reimbursement for this service shall be contingent on approval by the agency.

(c) The additional reimbursement for extra care shall be shown as a provider adjustment on the individual line item of benefit on the ICF-MR financial and statistical report. Extra care costs shall not be included as a component when calculating the final rate for the facility. The effective date of this regulation shall be April 1, 1992. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended April 1, 1992.)

30-10-213. ICF-MR cost reports. (a) Historical cost data.

(1) For cost reporting purposes, each provider shall submit the ICF-MR financial and statistical report in accordance with the instructions included in this regulation. The report shall cover a consecutive 12-month period of operations. The 12-month period shall coincide with the fiscal year used for federal income tax or other financial reporting purposes. The same 12-month period shall be used by providers related through common ownership, common interests or common control. A non-owner operator of a facility must have a signed provider agreement to be considered a provider for the purpose of this paragraph. A working trial balance, as defined in K.A.R. 30-10-200, and a detailed depreciation schedule shall be submitted with the cost report.

(2) If a provider has more than one facility, the provider shall allocate central office costs to each facility consistently, based on generally accepted accounting principles, including any facilities being paid rates from projected cost data.

(b) Amended cost reports. Amended cost reports revising cost report information previously submitted by a provider shall be required when the error or omission is material in amount and results in a change in the provider's rate of $.10 or more per client day. Amended cost reports shall also be permitted when the error or omission affects the current or future accounting periods of the provider. No amended cost report shall be allowed after 13 months have passed from the report year end.

(c) Due dates of cost reports. Cost reports shall be received by the agency no later than the close of business on the last day of the third month following the close of the period covered by the report. Cost reports from each provider with more than one facility shall be received on the same date.

(d) Extension of time for submitting a cost report to be received by the agency.

(1) A one-month extension of the due date of a cost report may, for good cause, be granted by the agency. The request shall be in writing and shall be received by the agency prior to the due date of the cost report. Requests received after the due date shall not be accepted.

(2) A second extension may be granted in writing by the secretary of the agency when the cause for further delay is beyond the control of the provider.

(3) Each provider who requests an extension of time for filing a cost report to delay the effective date of the new rate, which is lower than the provider's current rate, shall have the current rate reduced to the amount of the new rate. The reduced rate shall be effective on the date that the new rate would have been effective if the cost report had been received on the last day of the filing period without the extension.

(e) Penalty for late filing. Except as provided in subsection (d), each provider filing a cost report after the due date shall be subject to the following penalties.

(1) If the cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be withheld and suspended until the complete ICF-MR financial and statistical report has been received.

(2) Failure to submit cost information within one year after the end of the provider's fiscal year shall be cause for termination from the medicaid/medikan program.

(f) Projected cost data.

30-10-213 (3)

(1) If a provider is required to submit a projected cost report under K.A.R. 30-10-214, the provider's rate or rates shall be based on a proposed budget with costs projected on a line item basis for the provider's most immediate future 12-month period.

(2) The projection period shall end on the last day of a calendar month. Providers shall use the last day of the month nearest the end of the 12-month period specified in subparagraph (1) or the end of their fiscal year when that period ends not more than one month before or after the end of the 12-month report period. The projection period shall not be less than 11 months or more than 13 months. Historical cost data reported shall be for the full period reported if that period is less than 12 months or the latest consecutive 12-month period if the report period is extended beyond 12 months to meet this requirement.

(3) The projected cost report shall be approved for reasonableness and appropriateness by the agency before the rate or rates are established for the projection period, and upon receipt of the provider's historical cost report for the time period covered by the projected cost report. The projected cost report items which are determined to be unreasonable or which contain deviations from the historical cost report shall, upon audit, be handled in accordance with subsection (f) of K.A.R. 30-10-214.

(4) The projection period of each provider filing a projected cost report in accordance with paragraph (2) of subsection (e) of K.A.R. 30-10-214 shall be extended to the last day of the 12th month following the date the new construction is certified for use by the appropriate agency. The projected and historical cost reports for this projection period shall be handled in accordance